BENEFITS

Article 3.B. Calculation of Monthly Benefit Due to Partial Disability

(Applicable to Class 2 Only)

If you are Partially Disabled and if you are currently earning less than 80% of your Pre-disability Earnings, the following calculation is used to determine your Monthly Benefit:

A – (B x 50%) = C

where

A = The Monthly Benefit payable if you were otherwise Totally Disabled. (Disregard all other income from any employer or for any work when determining this figure).

B = Your Current Monthly Earnings received while Partially Disabled.

C = The Partial Monthly Benefit payable.

If a Monthly Benefit is payable for less than a month, The Hartford will pay 1/30 of the Monthly Benefit for each day you were Disabled.

BENEFITS

Article 4. Change in Coverage

Change in Class or Monthly Rate of Basic Earnings

Your coverage may increase or decrease on the date there is a change in your class or Monthly Rate of Basic Earnings.

No increase in coverage will be effective unless on that date you

(1) are an Active Full-Time Employee; and
(2) were not absent from work due to Disability during the 30 day period before the change in class or earnings.

A change in your Rate of Basic Earnings will become effective on the date The Hartford receives notice of the change.

Change in the Plan of Insurance

Any decrease in coverage because of a change in the Plan of Insurance will become effective on the date of the change. Any increase in coverage because of a change in the Plan of Insurance will become effective on the date of the change, subject to the following limitations:

(1) If you are absent from work due to Disability, the increase will not become effective until you return to work as an Active Full-Time Employee.
(2) If you are Disabled due to or contributed by a Pre-existing Condition which commenced prior to the increase, the increase will not become effective until the earlier of:

(a) the last day of a Treatment Free Period:

(i) which ends after the effective date of the change in the Plan of Insurance; and
(ii) during which no medical treatment, services, or supplies were received for the Pre-existing Condition; or

(b) the last day of a Period of Coverage:

(i) which began on the date of the change in the Plan of Insurance; and
(ii) during which you were continuously insured.

See the Plan of Insurance for the Treatment Free Period and the Period of Coverage.

BENEFITS

Article 6. Survivor Income Benefit

If you die:

(1) after having met the Elimination Period shown on the Plan of Insurance; or
(2) while receiving benefits under this plan,

then a lump sum payment equal to 3 times the Monthly Benefit:

(1) that would have been paid to you; or
(2) that was paid to you,

will be payable to your surviving Spouse.

If there is no surviving Spouse then benefits will be payable to your surviving children, in equal shares.

If there is no surviving Spouse or Child, no lump sum amount is payable.

If a minor Child is entitled to benefits, it is The Hartford's option to make benefit payments to the person caring for and supporting the Child until a legal guardian is appointed.

The following terms apply to Survivor Income Benefits:

(1) Spouse means your wife or husband who:

(a) is mentally competent; and
(b) was not legally separated from you at the time of your death.

(2) Children means your children, step-children, legally adopted children and foster children who, at the time of your death were:

(a) not yet 19 years old; or
(b) at least 19, but not yet 23; and

(i) attending school on a regular basis; and
(ii) dependent on you for financial support.

Section VI

EXCLUSIONS

Exclusions

The Plan does not cover and no benefit will be payable for any disability which:

(1) is caused by your commission of or attempt to commit:

(a) assault;
(b) battery; or
(c) felony;

(2) is due to:

(a) war;
(b) any act of war (declared or not);
(c) insurrection;
(d) rebellion;
(e) your taking part in a riot or civil disorder; or

(3) is due to or contributed to by a Pre-existing Condition.

Pre-Existing Conditions Limitations

The following exception(s) will apply to Exclusion (3):

(1) Exclusion (3) will cease to apply to a Pre-existing Condition on the first to occur of the following dates:

(a) the last day of 90 consecutive days while insured during which you did not receive Medical Care for the Pre-existing Condition; or
(b) the last day of 365 consecutive days during which you have been continuously insured under the Plan.

EXCLUSIONS

Pre-Existing Conditions Limitations (Continued)

(2) If you:

(a) become insured under this Plan on its effective date; and
(b) were insured under the long term disability insurance (here called the Prior Plan) carried by the Policyholder on the day before the effective date of this Plan;

then Exclusion (3) will cease to apply if you are Disabled due to or contributed by a Pre-existing Condition on the first to occur of the following dates:

(a) the policy effective date, if your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Plan; or
(b) the date this restriction would have ceased to apply, had the Prior Plan stayed in force.

If Exclusion (3) does not apply or ceases to apply only because of the preceding terms of this pre-existing condition limitation, benefit payments will be subject to both limitations below:

(a) No Monthly Benefit payment will exceed the lesser of the Monthly Benefit:

(i) which would have been paid by the Prior Plan; or
(ii) provided by this Plan.

(b) No payment shall be made after the earlier to occur of:

(i) the date payments would have ceased under the Prior Plan; or
(ii) the date payments cease under this Plan.

These exceptions will not apply to a period of Disability which commences on or after the earlier of the dates stated in item (1).

CLAIMS

Notice of Claim

You must give The Hartford written notice of a claim within 20 days after the loss happens or starts. If notice cannot be given within that time, it must be given as soon as possible. Such notice must include your name, your address and policy number.

Claim Forms

When The Hartford receives a notice of claim, you will be sent forms for providing The Hartford with proof of loss. The Hartford will send these forms within 15 days after receiving a notice of claim.

If The Hartford does not send the forms within 15 days, you may submit any other written proof which fully describes the nature and extent of your claim.

Proof of Loss

Written proof of loss must be sent to The Hartford within 90 days after the start of the period for which The Hartford owes payment. After that, The Hartford may require further written proof that you are still Disabled. If proof is not given by the time it is due, it will not affect the claim if:

(1) it was not possible to give proof within the required time; and
(2) proof is given as soon as possible; but
(3) not later than 1 year after it is due, unless you are not legally competent.

The Hartford has the right to require, as part of proof of loss:

(1) your signed statement identifying all Other Income Benefits; and
(2) proof satisfactory to The Hartford that you and your dependents have duly applied for all Other Income Benefits which are available.

The Hartford reserves the right to determine if proof of loss is satisfactory.

You will not be required to claim any retirement benefits which you may only get on a reduced basis.

CLAIMS

Payment of Claims

All payments are payable to you. Any payments owed at your death may be paid to your estate. If any payment is owed to:

(1) your estate;
(2) a person who is a minor; or
(3) a person who is not legally competent; then

The Hartford may pay up to $1,000 to any of your relatives who is entitled to it in the opinion of The Hartford. Any such payment shall fulfill The Hartford's responsibility for the amount paid.

Time Payment of Claims

If written proof of loss is furnished, accrued benefits will be paid at the end of each month that you are Disabled.

If payment for a part of a month is due at the end of the claim, it will be paid as soon as written proof of loss is received.

Appeal of Claims Denied

If a claim for benefits is wholly or partly denied, you will be furnished with written notification of the decision. This written decision will:

(1) give the specific reason(s) for the denial;
(2) make specific reference to the policy provisions on which the denial is based;
(3) provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and
(4) provide an explanation of the review procedure.

On any denied claim, you or your representative may appeal to The Hartford for a full and fair review.

You may:

(1) request a review upon written application within 60 days of the claim denial;
(2) review pertinent documents; and
(3) submit issues and documents in writing.

CLAIMS

Appeal of Claims Denied (Continued)

A decision will be made by The Hartford no more than 60 days after the receipt of the request, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after the request for review is received.

The written decision will include specific references to the policy provisions on which the decision is based.

Legal Actions

Legal action cannot be taken against The Hartford:

(1) sooner than 60 days after due proof of loss has been furnished; or
(2) after the shortest period allowed by the laws of the state where the policy is delivered. This is 3 years after the time written proof of loss is required to be furnished according to the terms of the policy.

Physical Examination

The Hartford may have you examined to determine if you are Disabled. Any such examination will be:

(1) at The Hartford's expense; and
(2) as reasonably required by The Hartford.

Conforming Instrument

For the purpose of meeting certain requirements of the Employee Retirement Income Security Act of 1974, the following information and the attached Claim Procedures and Statement of ERISA Rights are provided for use with your booklet-certificate to form the Summary Plan Description.

The benefits described in your review booklet are provided under a group policy by the Insurance Company and are subject to the terms and conditions of that policy.

A copy of this policy is available for your review during normal working hours in the office of the Plan Administrator.

1. **Plan Name**
   Group Long Term Disability Insurance Plan for Employees of Trustees of The Massachusetts Bankers Association Group Insurance Trust.

2. **Plan Number**
   501

3. **Employer/Plan Sponsor**
   Trustees of The Massachusetts Bankers Association
   Group Insurance Trust
   800 Boylston St.
   Prudential Tower, Suite 550
   Boston, Massachusetts 02199

4. **Employer Identification Number**
   04-158-1837

5. **Type of Plan**
   Welfare Benefit Plan Providing Group Long Term Disability Insurance

6. **Plan Administrator**
   Same as Employer/Plan Sponsor in Item 3.

Conforming Instrument (Continued)

7. **Agent for Service of Legal Process**
   The Hartford Life and Accident Insurance Company
   Hartford Plaza
   Hartford, Connecticut 06115
   In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

8. **Sources of Contributions** — The Employer pays the premium for the insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.

9. **Type of Administration** — The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group policy.

10. The Plan and its records are kept on a Policy Year basis.

11. **Labor Organizations**
    None

12. **Names and Addresses of Trustees**

    Mr. John F. Tierney, Jr., President
    BROADWAY NATIONAL BANK OF CHELSEA
    457 Broadway, Box 189
    Chelsea, Massachusetts 02150

    Ms. Susan M. Ginns, Senior Vice President & Treasurer
    BROOKLINE SAVINGS BANK
    160 Washington Street, P. O. Box F
    Brookline, MA 02147

    Mrs. Irene M. Charles, Exec. Vice-President
    CAPE COD BANK AND TRUST COMPANY
    307 Main St.
    Hyannis, Massachusetts 02601

    Mr. William J. Sloboda, Exec. Vice-President
    CENTURY BANK AND TRUST COMPANY
    102 Fellsway West
    Somerville, Massachusetts 02145

Conforming Instrument (Continued)

12. Names and Addresses of Trustees (Continued)

Mr. John B. Rice, Jr., President
FIRST AND OCEAN NATIONAL BANK
51 State Street
Newburyport, Massachusetts 01950

Mr. Herbert E. Claflin, Trust Officer
MALDEN TRUST COMPANY
94 Pleasant Street
Malden, Massachusetts 02148

Mr. Robert K. Sheridan, President
MASSACHUSETTS BANKERS ASSOCIATION
Prudential Tower, Room 550,
800 Boylston Street
Boston, Massachusetts 02199

Mr. Donald C. Carlson, Vice-President
SAUGUS BANK AND TRUST COMPANY
605 Broadway
Saugus, Massachusetts 01906

Mr. Michael Kwasniowski, Jr., President
SOUTH ADAMS SAVINGS BANK
2 Center Street, P.O. Box 306
Adams, MA 01220

Mr. Walter A. Kinnell, Jr. President
WESTBOROUGH SAVINGS BANK
100 East Main Street, P. O. Box 250
Westborough, Massachusetts 01581

Conforming Instrument
Statement of ERISA Rights

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

(i) Examine, without charge, at the plan administrator's office and at other locations (worksites and union halls), all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.

(ii) Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

(iii) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan reviewed and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance

Conforming Instrument (Continued)

Statement of ERISA Rights (Continued)

from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor Management Services Administration, Department of Labor.

Conforming Instrument
Claim Procedures

A. Claims for Benefits — An employee wishing to present a claim for benefits for himself or his insured dependents should obtain claim form or forms from his Employer or Administrator. The applicable section of such form or forms should be completed by (1) Employee, (2) Employer or Administrator and (3) Attending Physician or Hospital. Following completion, claim form or forms should be forwarded to the individual authorized to process and pay claims (Administrator or Insurance Company's Claim Representative). The individual authorized to process and pay the claims will compute benefits due, and will issue draft(s) in settlement. Unless the employee assigns benefits to a doctor or to a hospital, draft(s) will be made payable to the employee.

A decision will be made by the Insurance Company no more than 90 days after receipt of due proof of loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of loss is received. The written decision will include specific reasons for the decision and specific references to the plan provisions on which the decision is based.

B. Appealing Denial of Claims — If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to the employee. This written decision will:
   (a) give the specific reason or reasons for denial;
   (b) make specific reference to policy provisions on which the denial is based;
   (c) provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
   (d) provide an explanation of the review procedure.

On any denied claim an employee or his representative may appeal to the Insurance Company for a full and fair review. The claimant may:
   (a) request a review upon written application within 60 days of receipt of claim denial;
   (b) review pertinent documents; and
   (c) submit issues and comments in writing.

A decision will be made by the Insurance Company no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after the request for review is received. The written decision will include specified reasons for the decision and specific references to the plan provisions on which the decision is based.